REPORT OF ACTUAL OR SUSPECTED CHILD ABUSE OR NEGLECT

Michigan Department of Human Services

Was complaint phoned to DHS?

☐ Yes ☐ No ▶ If yes, Log # _____ ▶ If no, contact the local DHS Office immediately

INSTRUCTIONS: REPORTING PERSON: Complete items 1-21 (22-30 should be completed by medical personnel, if applicable). Send PART 1 to local County DHS where the child is found. Retain PART 2 for your records. See additional instructions on back.

1. Date

2. List of child(ren) suspected of being abused or neglected (list additional children on back of Part 1)

NAME	BIRTH DATE	SOCIAL SECURITY #	SEX	RACE

3. Mother's name			
4. Father's name			
5. Child(ren)'s address (No. & Street)	6. City	7. County	8. Phone No.
9. Name of alleged perpetrator of abuse or neglect	10. Relationship to child(ren)		
11. Person(s) the child(ren) living with when abuse/neglect occurred	12. Address, City & Zip Code where abuse/neglect occurred		

13. Describe injury or conditions and reason for suspicion of abuse or neglect (Attach additional sheets if necessary)

14. Source of Complaint (Check appropriate box)

☐ PHYSICIAN/PHYSICIAN'S ASSISTANT ☐ AUDIOLOGIST ☐ PSYCHOLOGIST ☐ CLERGY
☐ MEDICAL EXAMINER (Coroner) ☐ *SOCIAL WORKER ☐ PROFESSIONAL COUNSELOR ☐ MARRIAGE/FAMILY THERAPIST
☐ DENTIST/DENTAL HYGIENIST ☐ SCHOOL ADMINISTRATOR ☐ TEACHER ☐ DHS FACILITY
☐ NURSE ☐ SCHOOL COUNSELOR ☐ LAW ENFORCEMENT OFFICER ☐ DCH FACILITY
☐ EMERGENCY MEDICAL SERVICES PERSONNEL ☐ HOSPITAL ☐ CHILD CARE PROVIDER ☐ ELIGIBILITY SPECIALIST
☐ FAMILY INDEPENDENCE MANAGER ☐ FAMILY INDEPENDENCE SPECIALIST ☐ SOCIAL WORK SPECIALIST
☐ SOCIAL WORK SPECIALIST MANAGER ☐ WELFARE SERVICES SPECIALIST ☐ SOCIAL SERVICES SPECIALIST
☐ Other (Specify below)

15. Reporting person's name	16. Name of reporting organization (school, hospital, etc.)			
17. Address (No. & Street)	18. City	19. State	20. Zip Code	21. Phone No.

TO BE COMPLETED BY MEDICAL PERSONNEL WHEN PHYSICAL EXAMINATION HAS BEEN DONE

22. Summary report and conclusions of physical examination (Attach Medical Documentation)

23. Laboratory report	24. X-Ray
25. Other (specify)	26. History or physical signs of previous abuse/neglect ☐ YES ☐ NO

27. Prior hospitalization or medical examination for this child

DATES	PLACES

28. Physician's Signature	29. Date	30. Hospital (if applicable)

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: P.A. 238 of 1975.
COMPLETION: Mandatory.
PENALTY: None.

*INCLUDES LICENSED MASTER'S SOCIAL WORKER, LICENSED BACHELOR'S SOCIAL WORKER, SOCIAL SERVICE TECHNICIAN, REGISTERED SOCIAL SERVICE TECHNICIAN (Act No. 352, P.A. of 1972, as amended)